NORTH AURORA SMILES

CHILD DENTAL HISTORY

Patient's Name_____ Birthdate_____
What is the reason for your child's visit today?_____
Is this your child's first dental visit?_____
If not, was the previous visit a good one?_____
Has your child received local anesthetic before? **YES** **NO**
Did or does your child have a bottle at nap or bed time? **YES** **NO**
Does your child have a thumb habit or pacifier? **YES** **NO**
Who brushes your child's teeth?_____
How often are your child's teeth brushed?_____
How often are your child's teeth flossed?_____
Has your child had a serious problem at a previous dental visit? **YES** **NO**
If yes, please explain_____
_____
Do you believe your child can tolerate routine dental care? **YES** **NO**
If not, please explain_____
_____

CHILD MEDICAL HISTORY

Name of child's physician_____ Phone Number_____

Does your child have any allergies to medications? **YES** **NO**
If yes, please list_____

Any reactions to local anesthetics? **YES** **NO**

YES	**NO**	Asthma	**YES**	**NO**	Hearing Loss
YES	**NO**	Heart Disease/Murmur	**YES**	**NO**	Epilepsy or Seizures
YES	**NO**	Diabetes	**YES**	**NO**	Emotional Problems
YES	**NO**	Arthritis	**YES**	**NO**	Physical or Mental Disability
YES	**NO**	Prolonged Bleeding	**YES**	**NO**	Kidney Disease
YES	**NO**	Hepatitis	**YES**	**NO**	Hay Fever
YES	**NO**	Lung Disease	**YES**	**NO**	Anemia
YES	**NO**	Birth Defects	**YES**	**NO**	AIDS/AIDS Related Complex

Any Other Medical Conditions?_____
_____
Does your child require antibiotic prior to dental treatment? **YES** **NO**
List medications child is taking:_____
_____

Emergency Contact_____ Relationship_____
Phone Number_____

Doctor's Notes:_____
_____
_____

Parent or Guardian Signature_____ Date_____

Dentist Signature_____